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STATE OF DELAWARE
BOARD OF PHARMACY

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AFFIDAVIT OF PRECEPTOR

INSTRUCTIONS

This form is for Delaware Pharmacist Intern applicants who are attending or graduated from a school or college of Pharmacy in the U.S.

- The applicant completes the APPLICANT INFORMATION section and sends this form to his or her selected Delaware-licensed preceptor Pharmacist.
- The preceptor completes the INFORMATION ABOUT PRECEPTOR section, signs the form in the presence of a notary and sends it *directly* to the Board office at the address above.

APPLICANT INFORMATION

Applicant Name: _____

INFORMATION ABOUT PRECEPTOR

1. Name of Preceptor Pharmacist: _____
2. Pharmacist License Number: A1 - _____
3. Have you practiced as a pharmacist at least two years? Yes ☐ No ☐
4. Name of Pharmacy Where Intern Will Work: _____
5. Pharmacy Address: _____

   _____ DE _____
   City State Zip
6. Pharmacy's License Number: _____
7. Do you accept responsibility as the preceptor for the applicant named above? Yes ☐ No ☐
8. Do you agree to provide the applicant with the experience outlined in the Board's Practical Experience Program? Yes ☐ No ☐
9. If you terminate your preceptorship agreement with the applicant, do you agree to notify the Board office within ten calendar days and to file an *Affidavit of Intern Experience* form? Yes ☐ No ☐

AFFIDAVIT

I hereby certify that the information I have provided is accurate.

Signature of Preceptor: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires: _____

Send this form *directly* to the Board of Pharmacy office at the address above.

Revised 11/2017